WILD FERN NATURAL HEALTH POLICIES

Congratulations on making your health a priority by choosing Wild Fern Natural Health and naturopathic medicine to assist you in attaining your personal health goals. You are on your way! As licensed primary care providers in the state of Oregon, we can help your entire family address both acute and chronic health concerns with treatments such as routine, sleep, nutrition, hydrotherapy, botanicals/herbs, homeopathy, flower essences, and many other therapies. We are always delighted to co-manage healthcare with your other providers and fully support your informed choices about YOUR health care.

Establishing Care with Us - All new patients are required to establish care via an initial visit, during which your doctor will spend a significant amount of time (possibly longer than you are used to!) reviewing your personal health history. She will gather information about your current health concerns, priorities, and goals, developing a treatment plan to meet those needs. This visit will be directed toward prevention, prioritizing areas of concern, and conveying naturopathic philosophy as it pertains to your health issues and goals.

Scheduling - All scheduling happens by calling the Wild Fern Natural Health office at **(541) 708-0066**. Please schedule routine visits as early as possible to secure an appointment time that best suits your needs. If you are ill and need to be seen quickly, call the clinic early in the day to increase the chances of being fit into the day's schedule.

Apothecary or Prescription Refills - Apothecary items can be purchased during open clinic hours. Please call ahead to ensure we have the products you need or to make custom preparations. Payment can be taken over the phone and products set aside for your convenience during business hours. For pharmaceutical refill requests, your pharmacy can fax refill requests to **(541) 708-0971**. We require **at least 1 week advance notice** for refills of pharmaceuticals or custom preparations. Most apothecary products can also be ordered online 24/7 and shipped directly to your home via our Virtual Apothecary found at http://WildFernNaturalHealth.com/apothecary.

Contacting Your Doctor - There are TWO Ways to Communicate with Your Physician:

1. **In Person** - Your scheduled office visit is the best way to get focused, thorough care.
2. **By Phone** - The office manager can help answer questions or pass along a message to your physician.
    - Phone messages are always returned as quickly as possible.
    - The office manager will let you know if your question requires scheduling an appointment.

If you are experiencing a **medical emergency, call 911 or go to the Emergency Room or Urgent Care.

Fragrance Free Clinic - In order to be respectful of the chemical sensitivities of our patients, we ask that you refrain from applying products containing synthetic fragrance, such as lotion, perfume, cologne, etc. on days that you will be visiting our clinic.

Cell phones/Electronics - We aim to provide a serene atmosphere at the clinic. Please silence your cell phones while visiting the clinic. Please also refrain from taking calls or using laptops in the reception area. If it is necessary for you to take a call or get some work done on a computer while you are waiting, we ask that you do so outside.

FEES –
New Patients: All new patients are required to establish care with us via an initial visit. ***A 50% non-refundable deposit is required to schedule a New Patient Visit.***

Returning Patients: All returning visits, including in-office/phone/virtual visits, are scheduled according to the approximate time the doctor needs to address concerns, review lab results, perform procedures, etc. Visit fees are based upon this approximate time, the nature and complexity of the visit, as well as the physician's time spent pre- or post-visit. ***Payment in full is required at the time of each visit.***

No-Show/ Short-notice cancellations: You will be charged ***the full cost of your scheduled visit*** if you cancel your appointment with less than 24 hours' notice, if you arrive after the start-time of your appointment and cannot be seen, or if you do not arrive to your appointment at all. Please note: Patients who no-show or cancel with less than 24 hours' notice twice will be asked to prepay for any future visits.

Insurance Billing - If you are covered by health insurance, we can provide a bill, containing visit and diagnostic codes, for YOU to submit to your insurance carrier for potential reimbursement. We provide these bills only upon request, only on the day of service. We will not communicate with your insurer on your behalf regarding pre-authorization, coverage or reimbursement.

Informed consent:
I, ____, I have read and understand these Policies & Pricing at Wild Fern Natural Health and agree to these conditions. I understand that my deposit for establishing care is non-refundable and I agree to the conditions of the No-Show/Short Notice Cancellation Policy. I acknowledge that I am accepting treatment from a naturopathic doctor. I understand there are intrinsic differences between care received from naturopathic doctors and medical doctors. At this time, it is my decision to pursue naturopathic treatment for any condition I have. Also, I understand that, as with any medical treatment, there is no guarantee that this treatment will offer complete resolution of any or all condition that I may have. I have read, understood and been offered a copy of the health information privacy act.

______________________________ ______________________________
Patient Date

______________________________ ______________________________
Physician Date

OCTOBER 2018

PEDIATRIC HEALTH HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your child's medical record.

Date:

Name: *(Last, First, M.I.)*	☐ **M** ☐ **F**	**DOB**

Other healthcare practitioners:

Name:	**Type of practice:**	**Phone number:**

Please list your current health concerns for your child in order of their importance to you

Concern:	**Date of onset:**
1.	
2.	
3.	

☐ Yes ☐ No Traumas, Car Accidents, Injuries?

Surgeries and Hospitalizations:

Date	Reason	Hospital

Has your child ever had a blood transfusion?... ☐ Yes ☐ No

BIRTH HISTORY

Prenatal history:	☐ Yes ☐ No Did mother have any problems or illness during pregnancy? If so, describe:
Birth History:	☐ Vaginal ☐ Cesarean Section ☐ Forceps ☐Vacuum ☐ Trauma? ☐ On time ☐ Before 37 weeks of pregnancy ☐ After 42 weeks of pregnancy Any newborn problems? ☐ Jaundice ☐ Hospitalization ☐ Other, describe
Illness:	Has your child had antibiotics? If so, how many times?

DIET

Describe your baby's diet	If your child is eating solids, describe what she/he has eaten in the last 24 hours….
☐ Breastmilk only ☐ Formula ☐ Mixed	Time: Food eaten- describe ingredients Amount

PAST MEDICAL HISTORY

Does your child have, or has she/he had:

☐ Yes ☐ No	Chicken pox	☐ Yes ☐ No	Constipation requiring a doctor visit
☐ Yes ☐ No	Ear infections	☐ Yes ☐ No	Bladder or kidney infection
☐ Yes ☐ No	Problems with ears or hearing	☐ Yes ☐ No	Bed-wetting (if over 5 years old)
☐ Yes ☐ No	Nasal allergies	☐ Yes ☐ No	(girls) Started menstruating?
☐ Yes ☐ No	Problems with eyes or vision	☐ Yes ☐ No	(girls) Any problems with periods?
☐ Yes ☐ No	Asthma, bronchitis, croup or pneumonia	☐ Yes ☐ No	Chronic or recurrent skin problems
☐ Yes ☐ No	Heart problems or murmur	☐ Yes ☐ No	Frequent headaches
☐ Yes ☐ No	Anemia or bleeding problem	☐ Yes ☐ No	Seizures or other neurologic problems
☐ Yes ☐ No	Frequent abdominal pain	☐ Yes ☐ No	Diabetes or thyroid problems

FAMILY HEALTH HISTORY

Is your child adopted? .... ☐ Yes ☐ No
Have any family members had the following? If so, note relationship to child

☐ Yes ☐ No	Deafness	☐ Yes ☐ No	Bleeding disorder
☐ Yes ☐ No	Nasal Allergies/ Hayfever	☐ Yes ☐ No	Liver disease
☐ Yes ☐ No	Eczema	☐ Yes ☐ No	Kidney disease
☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Diabetes before age 50
☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Bed-wetting after age 10
☐ Yes ☐ No	Heart Disease before age 50	☐ Yes ☐ No	Epilepsy or convulsions
☐ Yes ☐ No	High Blood Pressure before age 50	☐ Yes ☐ No	Alcohol or drug abuse
☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Developmental disability
☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Mental illness

SOCIAL HISTORY AND DEVELOPMENT

Home Environment:

How many children in your home? Child's birth order (3rd of 4 kids…)

What adults live with your child?

Has your child had any traumas or losses?

School Age Children:

☐ Yes ☐ No Has he/she ever been "held back" or had to repeat a grade?

☐ Yes ☐ No Are you concerned about your child's attention span?

☐ Yes ☐ No Does your child like school?

☐ Yes ☐ No Any concerns about your child's behavior in school?

☐ Yes ☐ No Any concerns about how he/she is doing academically?

MEDICATIONS

INCLUDE **CURRENT** PRESCRIPTION MEDICATIONS, OVER THE COUNDER DRUGS, VITAMINS, HERBS ETC...

Start date	Name	Dose/ Strength	Frequency	

ALLERGIES

Name of Drug, environmental or food allergy	Reaction

PROBLEM LIST (leave this section blank, for physician use)

DATE		ICD-9

Date: ________________

Patient Name:		Secure message phone:
Date of birth:	M / F	Prefer reminders via: call ☐ text ☐ email ☐
Address:		Home phone: Cell phone: Work phone:
Email:		Will you be billing your insurance: Yes ☐ No ☐ (we do not provide billing services, only codes for your personal use)
Occupation (if applicable):		Employer (optional):
Guardian or Emergency Contact:		Family members (optional):
Other Physicians/ health providers:		Referred by / How did you hear about us?

Naturopathic Primary Care & Apothecary

www.WildFernNaturalHealth.com